Office of the
State Superintendent of Education

The Child and Adult Care Food Program (CACFP)

Adult Day Care Medical Substitution Form

Statement for Special Diet Prescription – Adult Day Care

The following adult is a participant in the United Stated Department of Agriculture (USDA) Adult Day Care component of the CACFP. USDA regulations 7CFR Part 15B requires substitution or modifications in program meals for adults whose disabilities restrict their diets. An adult with a disability must be supplied substitutions in foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made. The statement must include the following:

Part 1: To be completed by Participant/Caregiver

Participant's Name:	Date of Birth:
Name of Center/Program:	Gender: M F
Name of Caregiver/Guardian	In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act I hereby authorize (physician/medical authority name: _____) to release such protected health information as is necessary for the specific purpose of Special Diet information to (Program Name:_____) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on (Date:_____). This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the participant, guardian or authorized representative of the person listed on this document and has the legal authority to sign on behalf of that person. Participant/Guardian Signature:_____ Date:_____
Home Phone: / Work Phone:	
Street Address:	
City, State, Zip Code:	

Part 2: To be completed by Physician/Medical Authority

Recognized Medical Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or registered dietitian (RD).

Does the participant have a disability? Yes_____ No_____ If Yes, please describe the major life activities affected by the disability.	Does the participant have special nutritional or feeding needs? Yes_____ No_____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.
If the participant is not disabled, does he/she have special nutritional or feeding needs? Yes_____ No_____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.	Does the participant require emergency medication be administered? Yes_____ No_____ If yes, please list medication(s) and describe situation/reactions that would necessitate administrating.

Part 3: To be completed by a Recognized Medical Authority

Recognized Medical Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or registered dietitian (RD).

List any dietary restrictions or special diet:

List any food allergies or food intolerances:

List foods to be substituted (mandatory):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".

Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

List any special equipment or utensils needed:

Indicate any other comments about the participant's eating or feeding patterns:

Physician's Name and Office Phone Number:		Office Stamp
Physician's/Medical Authority Signature		Date

Part 4: Participant Signature

Participant or Guardian Signature (if signing on behalf of participant)		Date

Part 5: Program Official Signature

Program Official Signature		Date

*Please have participant/guardian review form annually and initial/date if no changes are required.
Any changes require submission of a new form signed by the Physician/Medical Authority.